PAIN MANAGEMENT SURGICAL BOOKING FORM

Please fax all bookings with a current HIPAA, relevant notes & diagnostic testing to 201-537-6894 or email to bookings@lynxmm.com. Thank you!

PATIENT INFORMATION

Name:	DOB:	Age:	☐M ☐F	SSN:
Street Address:	City:	State:	Zip:	
Home #:	Cell #:	E-Mail:	Language:	
Emergency Contact (Name & Relationship):			Phone #:	
Primary Physician Name:			Phone #:	

INSURANCE INFORMATION (Insurance card must accompany scheduling form (front & back))

Primary Ins Name:		Phone:	Policy #:
Subscriber Name:	DOB:	Relationship to Pt: ☐Self ☐Spouse ☐Parent ☐Other: _____	
Worker's Comp: Yes ☐ No ☐ ***PLEASE ATTACH AUTH LETTER*** No Fault: Yes ☐ No ☐	WCB#:	Case Claim #:	Phone #:
Is This A Lien: Yes ☐ No ☐ ***PLEASE ATTACH SIGNED LIEN***	Attorney Name:		Phone #:
Adjuster:	Auth #:	Date of Auth:	DOA/DOI:

SURGICAL PROCEDURE INFORMATION

Surgeon:	Assisting Surgeon:	Date Request #1: _____ #2: _____

☐ ESI: Level: _____ Side: _____	☐ Cervical (62310) ☐ Thoracic (62310) ☐ Lumbar (62311) ☐ Caudal (62311)	☐ MBB ☐ Facet Level: _____ Side: _____	☐ Cervical(64490) ☐ Thoracic (64490) ☐ Lumbar (64493)	☐ Diagnostic ☐ Confirmatory
☐ TFESI: Level: _____ Side: _____	☐ Cervical (64479) ☐ Thoracic (64479) ☐ Lumbar (64483)	☐ RF: Level: _____ Side: _____	☐ Cervical (64633) ☐ Thoracic (64633) ☐ Lumbar (64493) ☐ Sacroiliac (64635) ☐ Other: _____	
☐ Discogram: Level: _____ Side: _____	☐ Cervical (62291) ☐ Thoracic (62291) ☐ Lumbar (62290)	☐ Discectomy Level: _____ Side: _____	☐ Cervical (63020) ☐ Thoracic (63020) ☐ Lumbar (63030)	
☐ SCS Trial ☐ SCS Perm Level: _____ Side: _____	☐ Cervical (62291) ☐ Lumbar (62290)	☐ Sympathetic Nerve Block Level: _____ Side: _____	☐ Stellate Ganglion Block (64510) ☐ Lumbar (64520)	
☐ TPI (20552 / 20553) Location(s):			☐ Sacroiliac Joint Injection (27069)	
☐ BMAC (0263T) Location(s):			Side:	

☐ Other: _____

_____

DIAGNOSIS

☐ Cervical Pain (M54.2) ☐ Mid Back Pain (M54.6) ☐ Radiculopathy (☐Cervical(M54.12) ☐Lumbar(M54.16) ☐Thoracic(M54.14)

☐ Low Back Pain (M54.5) ☐ Sciatica (M54.3) ☐ Spondylolysis (☐Cervical(M43.02) ☐Lumbar(M43.06) ☐Thoracic(M43.04)

☐ Herniated NP (M51.9) ☐ CRPS (G90.50) ☐ Facet Syndrome (M54.08) ☐ Other:

_____

SPECIAL REQUESTS

Equipment/Vendor:	Supplies:
Instrumentation:	Other:

PREOPERATIVE MEDICAL CLEARANCE

SCS Trial/Perm & Discectomy Patients require: H&P, EKG, Chest X-Ray, Blood Work (CBC w/ iff, CMP, PT/PTT) & Clean Catch UA

Clearing Physician/Clinic: _____ Phone: _____

SURGICAL SCHEDULER'S INFORMATION

Name:		Office/Clinic:
Phone:	E-Mail:	Booked By:

Surgeon Signature: _____ Date: _____ Reviewed By: _____

PLACE OF SERVICE SELECTION FORM

This is to notify you that Dr. _____ has concluded that your treatment requires a surgical procedure to be performed. An accredited, licensed surgical facility is required to perform the procedure. Below are the locations the above physician and/or his group perform their procedures.

□ Health East Ambulatory Surgical Center – Englewood, NJ
(*If selected, **must** fill out Disclosure of Financial Interest in Surgical Center below*)

□ Other: _____

ACKNOWLEDGEMENT

I have read this "Place of Service Selection" form, and I understand by signing this form, I wish to proceed with my surgical procedure at the above location.

_____ _____ _____
Patient Signature Patient Name (Print) Date

DISCLOSURE OF FINANCIAL INTEREST IN SURGICAL CENTER

Public law/rule of the State of New Jersey/Board of Medical Examiners mandates that a physician, podiatrist and all other licensees of the Board of Medical Examiners inform patients of any significant financial interest held in a health care service. Accordingly, please take notice that practitioners do have a financial interest in CTO Management, LLC, d/b/a Health East Ambulatory Surgical Center where patients are referred.

You may, of course, seek treatment at a health care service provider of your own choice. A listing of alternative health care service providers can be found in the classified section of your telephone directory under the appropriate heading.

Additionally, the Centers for Medicare & Medicaid Services Conditions of Coverage regarding ambulatory surgical centers mandate that ambulatory surgical centers disclose to patients a physician's financial interest in an ambulatory surgical center to which the physician refers his or her patients. Accordingly, please take notice of the following are Physician with ownership or control interests in CTO Management, LLC, d/b/a Health East Ambulatory Surgical Center:

CTO Management, LLC, d/b/a Health East Ambulatory Surgical Center is owned partly by Anson Moise, M.D., Jason Baynes, M.D., David Capiola, M.D., Matthew Chalfin, M.D., David R. Adin, D.O., Christopher Kyriakides, D.O., Ronald Krinick, M.D., and Thomas Scilaris, M.D.

Please sign below to acknowledge that you have been informed of the ownership or control interest in the above entities at the time you were referred to the above entity and prior to your schedule procedure.

_____ _____ _____
Patient's Signature Patient Name (Print) Date

NON-PARTICIPATING PROVIDER DISCLOSURE & CONSENT FORM

Please be advised that the procedure(s) you are scheduled to undergo at CTO Management, LLC, d/b/a Health East Ambulatory Surgical Center will be considered to be "out-of-network services, and reimbursed at an "out-of-network" level by your insurance carrier. By signing this agreement, you understand that all applicable co-payments and or deductibles are due at time of service. You agree to be financially responsible for full payment for all charges not cover by your insurance company. You authorize your insurance to make direct payment to CTO Management, LLC, d/b/a Health East Ambulatory Surgical Center for the services rendered. You accept all identified cost and estimates as indicated. You also acknowledge the provider participation status and understand that additional cost may be incurred and Out of Network Benefits may be used as a result of being treated by providers affiliated with **Health East 54 South Dean Street Englewood, NJ 07631**.

_____ _____ _____
Patient's Signature Patient Name (Print) Date

AUTHORIZATION FOR THE USE AND DISCLOSURE OF MEDICAL INFORMATION

I, _____ hereby authorize _____ to use and/or disclose a copy of my medical records containing individually identifiable health information as described below. I understand that this authorization is voluntary. I also understand that, if the organization authorized to receive the information is not a health care provider or health plan, the released information may no longer be protected by state or Federal privacy laws or this authorization.

Patient Name: _____ DOB: _____

I authorize _____
(Name of the person/organization authorized to receive the information)

_____
(Address of the person/organization authorized to receive the information)

_____
(Phone Number of the person/organization authorized to receive the information)

and its affiliates to retrieve the above individual's "Protected Health Information" from _____ _____.

Description of information to be Used and / or Disclosed (such as dates of service or treatment, type of service or treatment, level of detail to be released or origin of information):

_____
_____
_____
_____
_____

This medical information is being used and/or disclosed for the following purpose(s) ("at the request of the individual" is sufficient if the request is made by the patient and the patient does not want to state a specific purpose):

_____
_____
_____

Expiration: This authorization will expire on _____ / _____ / _____, OR
The event that relates to the use and/or disclosure occurs and this Authorization is no longer necessary. This expiration event is:

_____
_____

AUTHORIZATION FOR THE USE AND DISCLOSURE OF MEDICAL INFORMATION

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to the Privacy Officer. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I also understand that my physician will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except (1) if my treatment is released to research or (2) if health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of this form.

_____

Signature of Patient or Personal Representative

_____

Date

_____

Print Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority